MEDICAL CLAIM FORM
KCDRB Form 9A
LEOFF-1 Assessment of Need for Assisted Living Care: Claimant or Power of Attorney

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call your employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by Claimant or Power of Attorney.

LEOFF-1 member/claimant's name: _____ Date of Birth: _____

Power of Attorney: _____ Phone: _____

POA address: _____

City: _____ State: _____ ZIP: _____

Type of accommodation (e.g. one bedroom, other): _____

Long-term care insurance? ☐ Yes ☐ No

Attach itemized statement showing each service, cost and date provided (**required**).

Name of insurance carrier: _____ Policy No.: _____

Signature: _____ Date: _____

LEOFF-I claimant or power of attorney

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.

Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 9B
LEOFF-1 Assessment of Need for Assisted Living Care: Director of Nursing or Assisted Living

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call the employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by director of nursing or assisted living.

Director of nursing: _____ Phone: _____

Name of assisted living care facility: _____

Street address of facility: _____

City: _____ State: _____ ZIP: _____

Date of admittance to facility: _____

Level of care required at admittance: _____

Current level of care required (copy of care plan **required)**: _____

Signed: _____ Date: _____
Director of Nursing or Assisted Living

_____
Print Name

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Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 9C
LEOFF-1 Assessment of Need for Assisted Living Care: Facility Medical Director Physician or Resident's Primary Health Care Provider

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call the employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by facility medical director physician or resident's primary health care provider.

(Dictate for typing or print ONLY.)

Name of resident: _____

Medical director physician or primary health care provider: _____ Phone: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Diagnosis upon admission to facility: _____

History of illness/condition leading up to placement: _____

Patient's prognosis for recovery: _____

Current level of functioning: _____

Current medication (please attach printed list to include name, dosage, frequency): _____

Other providers involved in patient's care since admission: _____

What treatment services have been prescribed (physical therapy, speech therapy, etc.)? Attach treatment plans for ***each*** service **(required)**. _____

What treatment services have been prescribed (physical therapy, speech therapy, etc.)? Attach treatment plans for ***each*** service **(required).** _____

Signed: _____ Date: _____
Medical director physician/primary health care provider

_____
Printed Name

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Revised 3/2020